

GIC Retiree Dental Plan Handbook

MetLife®



YOUR BENEFIT PLAN

Commonwealth of Massachusetts

RETIREE DENTAL PLAN offered through the Group Insurance Commission

Group Number: 122749

Who can enroll in the GIC Retiree Dental Plan?

All Commonwealth of Massachusetts retirees, survivors and retired municipal teachers in the GIC RMT program and Elderly Governmental Retirees can enroll. If you have questions about whether or not you or your dependents are eligible, please contact the Group Insurance Commission at 617-727-2310. **If you have questions about the dental plan benefits, please call MetLife at 1-866-292-9990.**

When can you enroll?

You can enroll in the dental plan:

- Upon retirement
- When your COBRA Dental coverage ends
- During the GIC's Annual Enrollment

When does Coverage Begin?

Coverage begins the first of the month following acceptance by the GIC of a completed and signed enrollment form.

When does coverage end?

Your insurance will end on the earliest of:

- the date the Group Policy ends;
- the date you cease to be eligible;
- the last day of the calendar month in which premium was paid.

If you drop your Dental coverage, you will never be allowed to rejoin the Plan. Please see question 8 on page 3 for further details.

What is the monthly cost of the retiree dental plan:

Effective 7/1/2007, the monthly rates are:

- Single only: \$23.93
- Family: \$57.64

Do I need an ID card?

ID cards are not required. Your dentist is able to verify that you are eligible for benefits by calling 1-866-292-9990, and providing your name and Social Security Number.

If you would like an ID card, you can obtain one online at www.metlife.com/GIC or call 1-866-292-9990.

What happens if my claims exceed the annual maximum of \$850?

You are responsible for any charges above the annual maximum. However, if you are using a network dentist, you will pay the discounted amount.

Dental Plan Features

The GIC Dental Group number is **122749**.

The complete list of Covered Services with the maximum amounts payable is provided in this handbook.

The annual benefit maximum is \$850 per member, per calendar year.

Orthodontic Coverage is not available under the GIC Retiree Dental Plan.

Pre-treatment estimates are recommended for any treatment that costs more than \$150.

There are no individual or family deductibles.

Note: You must be enrolled in this program for six months before you will be covered for certain major services.

SUMMARY OF PRIMARY COVERED SERVICES

Your dental plan provides benefits for any covered service that is necessary as determined by MetLife in terms of generally accepted dental standards.

	How Many/How Often
Prophylaxis (cleanings) Oral Examinations Topical Fluoride Applications X-rays Sealants	<ul style="list-style-type: none"> • Two cleanings per calendar year. • Two oral exams per calendar year. • Fluoride treatment for children twice per calendar year. • One complete X-rays series or panoramic film: one every five years. • One bitewing X-rays series per calendar year: Single x-rays as required. • Sealants for children under age 19, once per permanent molar in a three year period.
Fillings Emergency Care Denture, Crowns and Bridge Repair	<ul style="list-style-type: none"> • Fillings -amalgam (silver) fillings on all teeth composite (white) fillings on front teeth, on the back teeth, plan pays for what would have been paid for an amalgam filling. • Procedures necessary to relieve acute pain twice per calendar year. • Repairs to existing partial or complete dentures once every 12 months. • Recementing crowns or bridges. • Rebasing or relining of partial or complete dentures, once every 5 years.
Simple Extractions Crown, Denture, and Bridge Repair Bridges and Dentures Endodontics General Anesthesia Periodontics	<p>You must be enrolled in this program for six months before you will be covered for the following services</p> <ul style="list-style-type: none"> • Extractions and other routine oral surgery, when not covered by a patient's medical plan. • Bridges, build up, post and cores- replacement limited to once every five years. • Crown lengthening, once per site every 5 years. • Crowns over natural teeth, build ups, posts and cores-replacement limited to once every 5 years. • Partial and complete dentures, replacement limited to once every 5 years. • Gingivectomies once every 24 months. • General anesthesia or intravenous (I.V) sedation for complex surgical procedures. • Root canal therapy. • Root planing once per quadrant, every 24 months. • Osseous(bone) surgery once per quadrant every 24 months (bone grafts excluded). • Periodontal maintenance following active therapy- two per year.

If you use a PDP dentist, you will continue to benefit from the discounted fees, even after you exceed the \$850 annual plan maximum.

COMMON QUESTIONS...IMPORTANT ANSWERS

1. **I was enrolled in the GIC Dental Plan as an active employee. Do I still have to satisfy the 6 month waiting period to be covered for major services.**

Yes. This is a plan requirement under the Retiree Dental Program.

2. **What is a participating PDP dentist?**

A participating dentist is a general dentist or specialist who accepts a schedule of reduced fees for services rendered to individuals covered under the MetLife benefit dental plan. **PDP fees typically range from 10-35% below the average fees charged by dentists in your area for the same or substantially similar services.**

3. **How do I find a participating PDP dentist?**

As of July 1st 2007, there were more than 100,000 participating PDP dentist locations nationwide, including more than 2,100 General Dentist and 600 specialists in Massachusetts. You can get a list of these participating PDP dentists and their locations online at www.metlife.com/GIC or call the toll free number 1-866-292-9990 to have a list faxed or mailed to you.

4. **Does the Preferred Dentist Program (PDP) offer PDP fees on non-covered services?**

Yes. The PDP in-network scheduled fees extend even to non-covered services, such as cosmetic dentistry or orthodontia, providing plan participants with savings on these non-covered services as well. You will pay the full cost for non-covered services. However, you will be able to full advantage of the PDP fees if the noncovered services are provided by a PDP dentist.

5. **May I choose a non-participating dentist?**

Yes. You are always free to select the dentist of your choice. However, if you choose a dentist who does not participate in the MetLife PDP, your out-of-pocket expenses may be more, since you will be responsible to pay for any difference between the dentist's fee and your plan's payment. If you receive services from a participating PDP dentist, you are only responsible for the difference between the PDP in-network fee for the covered service and your plan's payment. With both the PDP dentist and the non-PDP dentist, benefits are based on the lowest cost of method of treatment so long as it meets generally accepted dental standards. Of course, if you and your dentist agree to the more expensive procedure, you will be liable for the difference between the PDP fee for the more expensive procedure and the plan benefit.

6. **Can my dentist apply for PDP participation?**

Yes. If your current dentist does not participate in the PDP and you'd like to encourage him or her to apply to become a PDP dentist, tell your dentist to visit www.metdental.com or call 1-877-MET-3379 for an application. Website and phone number are designed for use by dental professionals only.

7. **How are claims processed?**

Your dentist may submit your claims for you which helps to reduce your paperwork. You can track your claims online and even receive e-mail alerts when a claim has been processed. If you need a claim form, you can find one online at www.metlife.com/GIC or request one by calling the toll free number 1- 866-292-9990.

8. **If I terminate can I rejoin the plan?**

If you have family coverage and switch to an individual plan, your spouse and/or your eligible dependents can never rejoin the dental plan. Also, if you sign up for individual coverage and decide to cancel, you can not rejoin the plan.

SUMMARY OF SERVICES NOT COVERED BY THE *PLAN*

The *plan* does not cover dental services:

- When those services do not qualify for payment according to our written guidelines, which assist us in making determinations as to whether services are covered and whether a particular service is the most cost-effective, commonly performed method of prevention, diagnosis or treatment. A service may not qualify for coverage under these guidelines even though it was furnished or recommended by a dentist. If we deem a service to be not covered, you may request in writing that we provide you with the written evaluation and findings supporting this decision.
- Certain procedures that are considered to be part of a more comprehensive procedure.
- Unless specifically covered in the Certificate.
- Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
- For an illness or injury that we determine arose out of and in the course of employment.
- For which you are not required to pay, or for which you would not be required to pay if you did not have this Certificate or for which no charge would have been made in the absence of this Certificate.
- Services or supplies which are deemed experimental in terms of generally accepted dental standards.
- For an illness, injury or dental condition for which benefits in one form or another are available, in whole or in part, through a government program or would have been available if you did not have this Certificate. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include Medicaid or Medicare.
- Rendered by someone other than a licensed dentist or a licensed hygienist if operating as authorized by applicable law.
- For consultations.
- To treat disorders of the joints of the jaw (temporo-mandibular joints - TMJ).
- To increase the height of teeth (increase vertical dimension) or restore occlusion.
- For restorations for reasons other than decay or fracture, such as erosion, abrasion, or attrition.
- That is meant primarily to change or to improve your appearance.
- For occlusal guards.
- For implants, bone grafts and transplants.
- For periodontal splinting to stabilize teeth when required due to periodontal disease.
- For any laboratory or bacteriological tests or reports.
- For temporary, complete dentures or temporary, fixed bridges or crowns.
- Related to congenital anomalies.
- For prescription drugs.
- For general anesthesia or intravenous sedation when rendered by anyone other than a dentist.
- For general anesthesia or intravenous sedation for non-surgical extractions, diagnostic, preventive, or minor restorative services.
- Orthodontics.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy [(Policy form GPNP99)] issued by MetLife. Coverage terminates when your membership ceases; when your dental contributions cease; upon termination of the group policy by the Policyholder; for non-payment of premium; or, if participation requirements are not met. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Like most group health insurance policies, MetLife group policies contain certain exclusions, limitations, waiting periods and terms for keeping them in force. Your group policy and certificate will provide details of your benefits and will control over this benefit summary. Please contact MetLife for complete details.

LIST OF MAXIMUM PAYMENTS

Procedure Code	Description	Maximum Payment Effective July 2007	* 6 month waiting period applies
00120	Periodic Oral Evaluation	\$27.00	
00140	Limited Oral Evaluation - problem focused	\$48.00	
00145	Oral Evaluation for patient under age of 3	\$33.00	
00150	Comprehensive Oral Evaluation - new or established patient	\$50.00	
00160	Detailed and Extensive Oral Evaluation - problem focused, by report	\$52.00	
00170	Limited Oral Re-evaluation - problem focused	\$32.00	
00180	Comprehensive Periodontal Evaluation - new or established patient	\$50.00	
00210	Intraoral - complete series (including bitewings)	\$94.00	
00220	Intraoral - periapical first film	\$17.00	
00230	Intraoral - periapical each additional film	\$15.00	
00240	Intraoral - occlusal film	\$28.00	
00250	Extraoral - first film	\$32.00	
00260	Extraoral each Additional Film	\$24.00	
00270	Bitewing - single film	\$16.00	
00272	Bitewings - two films	\$32.00	
00273	Bitewings - three films	\$39.00	
00274	Bitewings - four films	\$45.00	
00277	Vertical Bitewings - 7 to 8 films	\$45.00	
00290	Skull/Facial Bone X-Ray	\$62.00	
00330	Panoramic Film	\$79.00	
00350	Oral/Facial Images	\$69.00	
00415	lab test - collection of microorganisms for culture and sensitivity	\$40.00	
00421	lab test - genetic test for susceptibility to oral diseases	\$18.00	
00460	Pulp Vitality Tests	\$40.00	
00470	Diagnostic Casts	\$68.00	
01110	Prophylaxis - Adult	\$75.00	
01120	Prophylaxis - Child	\$57.00	
01203	Topical Application of Fluoride (Prophylaxis Not Included) - Child	\$26.00	
01204	Topical Application of Fluoride (Prophylaxis Not Included) - Adult	\$26.00	
01351	Sealant - Per Tooth	\$40.00	
01510	Space Maintainer - Fixed - Unilateral	\$84.00	
01515	Space Maintainer - Fixed - Bilateral	\$140.00	
01520	Space Maintainer - Removable - Unilateral	\$95.00	
01525	Space Maintainer - Removable - Bilateral	\$149.00	
01550	Recementation of Space Maintainer	\$20.00	
02140	Amalgam - One Surface, Primary or Permanent	\$51.00	
02150	Amalgam - Two Surfaces, Primary or Permanent	\$64.00	
02160	Amalgam - Three Surfaces, Primary or Permanent	\$78.00	

LIST OF MAXIMUM PAYMENTS

Procedure Code	Description	Maximum Payment Effective July 2007	* 6 month waiting period applies
02161	Amalgam - Four or More Surfaces, Primary or Permanent	\$92.00	
02330	Resin-Based Composite - One Surface, Anterior	\$58.00	
02331	Resin-Based Composite - Two Surfaces, Anterior	\$80.00	
02332	Resin-Based Composite - Three Surfaces, Anterior	\$99.00	
02335	Resin-Based Composite - Four or More Surfaces or Involving Incisal Angle (Anterior)	\$116.00	
02390	Resin-Based Composite Crown, anterior	\$116.00	
02391	Resin-Based Composite - one surface, posterior	\$58.00	
02392	Resin-Based Composite - two surfaces, posterior	\$81.00	
02393	Resin-based Composite, three surfaces, posterior	\$78.00	
02394	Resin-Based Composite, four or more surfaces, posterior	\$92.00	
02510	Inlay - Metallic - One Surface	\$50.00	*
02520	Inlay - Metallic - Two Surfaces	\$62.00	*
02530	Inlay - Metallic - Three or More Surfaces	\$77.00	*
02542	Onlay - Metallic - Two Surfaces	\$288.00	*
02543	Onlay - Metallic - Three Surfaces	\$339.00	*
02544	Onlay - Metallic - Four or More Surfaces	\$339.00	*
02610	Inlay - Porcelain/Ceramic - One Surface	\$50.00	*
02620	Inlay - Porcelain/Ceramic - Two Surfaces	\$62.00	*
02630	Inlay - Porcelain/Ceramic - Three or More Surfaces	\$77.00	*
02642	Onlay - Porcelain/Ceramic - Two Surfaces	\$288.00	*
02643	Onlay - Porcelain/Ceramic - Three Surfaces	\$339.00	*
02644	Onlay - Porcelain/Ceramic - Four or More Surfaces	\$339.00	*
02650	Inlay - Resin-Based Composite - One Surface	\$50.00	*
02651	Inlay - Resin-Based Composite - Two Surfaces	\$62.00	*
02652	Inlay - Resin-Based Composite - Three or More Surfaces	\$77.00	*
02662	Onlay - Resin-Based Composite - Two Surfaces	\$288.00	*
02663	Onlay - Resin-Based Composite - Three Surfaces	\$339.00	*
02664	Onlay - Resin-Based Composite - Four or More Surfaces	\$339.00	*
02710	Crown - Resin Based Composite (Indirect)	\$158.00	*
02712	Crown - 3/4 Resin Based Composite (Indirect)	\$158.00	*
02720	Crown - Resin With High Noble Metal	\$326.00	*
02721	Crown - Resin with Predominantly Base Metal	\$275.00	*
02722	Crown - Resin with Noble Metal	\$298.00	*
02740	Crown - Porcelain/Ceramic Substrate	\$385.00	*
02750	Crown - Porcelain Fused to High Noble Metal	\$385.00	*
02751	Crown - Porcelain Fused to Predominantly Base Metal	\$333.00	*
02752	Crown - Porcelain Fused to Noble Metal	\$356.00	*
02780	Crown - 3/4 Cast High Noble Metal	\$326.00	*
02781	Crown - 3/4 Cast Predominantly Base Metal	\$275.00	*
02782	Crown - 3/4 Cast Noble Metal	\$298.00	*

LIST OF MAXIMUM PAYMENTS

Procedure Code	Description	Maximum Payment Effective July 2007	* 6 month waiting period applies
02783	Crown - 3/4 Porcelain/Ceramic	\$326.00	*
02790	Crown - Full Cast High Noble Metal	\$385.00	*
02791	Crown - Full Cast Predominantly Base Metal	\$333.00	*
02792	Crown - Full Cast Noble Metal	\$356.00	*
02794	Crown - Titanium	\$385.00	*
02910	Recement Inlay, Onlay, or Partial Coverage Restoration	\$37.00	
02915	Recement Cast or Prefabricated Post and Core	\$37.00	
02920	Recement Crown	\$37.00	
02930	Prefabricated Stainless Steel Crown - Primary Tooth	\$70.00	*
02931	Prefabricated Stainless Steel Crown - Permanent Tooth	\$70.00	*
02932	Prefabricated Resin Crown	\$70.00	*
02933	Prefabricated Stainless Steel Crown with Resin Window	\$84.00	*
02934	Prefabricated Esthetic Coated Stainless Steel Crown - primary tooth	\$84.00	*
02940	Sedative Filling	\$37.00	
02950	Core Buildup, Including Any Pins	\$59.00	*
02951	Pin Retention - Per Tooth, in Addition to Restoration	\$21.00	
02952	Cast Post and Core in Addition to Crown	\$116.00	*
02953	Each additional indirectly fabricated post - same tooth	\$55.00	*
02954	Prefabricated Post and Core in Addition to Crown	\$91.00	*
02957	Each additional prefabricated post - same tooth	\$26.00	*
02960	Labial Veneer (resin laminate) - chairside	\$125.00	*
02961	Labial Veneer (resin laminate) - laboratory	\$300.00	*
02962	Labial Veneer porcelain laminate) - laboratory	\$350.00	*
02971	Additional procedures to construct new crown under existing partial denture framework	\$47.00	*
02980	Crown Repair, by Report	\$78.00	*
03110	Pulp Cap - direct (excluding final restoration)	\$20.00	*
03120	Pulp Cap - indirect (excluding final restoration)	\$20.00	*
03220	Therapeutic Pulpotomy (Excluding Final Restoration)	\$46.00	*
03221	Pulpal Debridement, primary and permanent teeth	\$42.00	*
03230	Pulpal Therapy (restorable filling) - anterior, primary tooth (excluding final restoration)	\$84.00	*
03240	Pulpal Therapy (restorable filling) - posterior, primary tooth (excluding final restoration)	\$90.00	*
03310	Root Canal Therapy Anterior, excluding final restoration	\$199.00	*
03320	Root Canal Therapy Bicuspid, excluding final restoration	\$242.00	*
03330	Root Canal Therapy Molar, excluding final restoration	\$350.00	*
03331	Treatment of root canal obstruction; non-surgical access	\$60.00	*
03332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$120.00	*
03333	Internal root repair of perforation defects	\$100.00	*
03346	Retreatment of Previous Root Canal Therapy - Anterior	\$215.00	*

LIST OF MAXIMUM PAYMENTS

Procedure Code	Description	Maximum Payment Effective July 2007	* 6 month waiting period applies
03347	Retreatment of Previous Root Canal Therapy - Bicuspid	\$267.00	*
03348	Retreatment of Previous Root Canal Therapy - Molar	\$382.00	*
03351	Apexification/Recalcification - Initial Visit	\$41.00	*
03352	Apexification/Recalcification - Interim Medication Replacement	\$25.00	*
03353	Apexification/Recalcification - Final Visit	\$41.00	*
03410	Apicoectomy/Periradicular Surgery - Anterior	\$161.00	*
03421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	\$161.00	*
03425	Apicoectomy/Periradicular Surgery - Molar (First Root)	\$161.00	*
03426	Apicoectomy/Periradicular Surgery (Each Additional Root)	\$108.00	*
03430	Retrograde Filling - Per Root	\$54.00	*
03450	Root Amputation - Per Root	\$113.00	*
03920	Hemisection (Including Any Root Removal)	\$108.00	*
04210	Gingivectomy or Gingivoplasty - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	\$161.00	*
04211	Gingivectomy or Gingivoplasty - One to Three Contiguous Teeth or Bounded Tooth Spaces Per Quadrant	\$47.00	*
04240	Gingival Flap Procedure, Including Root Planing - Four or More Contiguous Teeth or Bounded Teeth Spaces per Quadrant	\$215.00	*
04241	Gingival Flap Procedure, Including Root Planing - one to three contiguous teeth or bounded teeth spaces, per quadrant	\$129.00	*
04245	Apically Positioned Flap	\$88.00	*
04249	Clinical Crown Lengthening - Hard Tissue	\$226.00	*
04260	Osseous Surgery (Including Flap Entry and Closure) - Four or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	\$377.00	*
04261	Osseous Surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces, per quadrant	\$226.00	*
04263	Bone Replacement Graft - First Site in Quadrant	\$89.00	*
04264	Bone Replacement Graft - Each Additional Site in Quadrant	\$81.00	*
04265	Biologic Materials to aid in soft and osseous tissue regeneration	\$124.00	*
04266	Guided Tissue Regeneration - restorable Barrier, per Site	\$188.00	*
04267	Guided Tissue Regeneration - Nonrestorable Barrier, per Site	\$188.00	*
04268	Surgical Revision Procedure - per tooth	\$168.64	*
04270	Pedicle Soft Tissue Graft Procedure	\$226.00	*
04271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	\$226.00	*
04273	Subepithelial Tissue Graft per tooth	\$262.00	*
04274	Distal or Proximal Wedge Procedure	\$106.00	*
04275	Soft Tissue Allograft	\$262.00	*
04276	Combined Tissue and Double Pedicle Graft, per tooth	\$228.00	*
04341	Periodontal Scaling and Root Planing - Four or More Teeth Per Quadrant	\$63.00	*
04342	Periodontal Scaling and Root Planing - one to three teeth, per quadrant	\$38.00	*

LIST OF MAXIMUM PAYMENTS

Procedure Code	Description	Maximum Payment Effective July 2007	* 6 month waiting period applies
04355	Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis	\$28.00	*
04381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	\$30.00	*
04910	Periodontal Maintenance	\$39.00	*
05110	Complete upper denture	\$374.00	*
05120	Complete lower denture	\$374.00	*
05130	Immediate upper denture	\$396.00	*
05140	Immediate lower denture	\$396.00	*
05211	Partial upper denture resin base	\$315.00	*
05212	Partial lower denture resin base	\$315.00	*
05213	Partial upper denture cast metal frame	\$425.00	*
05214	Partial lower denture cast metal frame	\$425.00	*
05225	Partial upper denture flexible base (incl. clasps, rests and teeth)	\$425.00	*
05226	Partial lower denture flexible base (incl. clasps, rests and teeth)	\$425.00	*
05281	Removable unilateral partial denture - One Piece Cast Metal (Including Clasps and Teeth)	\$218.00	*
05410	Adjust complete upper denture	\$32.00	
05411	Adjust complete lower denture	\$32.00	
05421	Adjust partial upper denture	\$32.00	
05422	Adjust partial lower denture	\$32.00	
05510	Repair broken complete denture base	\$62.00	
05520	Replace missing or broken teeth - complete denture (each tooth)	\$56.00	
05610	Repair resin denture Base	\$60.00	
05620	Repair Cast Framework	\$95.00	
05630	Repair or Replace Broken Clasp	\$95.00	
05640	Replace Broken Teeth - Per Tooth	\$52.00	
05650	Add tooth to existing partial denture	\$86.00	
05660	Add clasp to existing partial denture	\$86.00	
05670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$159.00	
05671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$159.00	
05710	Rebase complete upper denture	\$159.00	
05711	Rebase complete lower denture	\$159.00	
05720	Rebase partial upper denture	\$155.00	
05721	Rebase partial lower denture	\$155.00	
05730	Reline complete upper denture chairside	\$112.00	
05731	Reline complete lower denture chairside	\$112.00	
05740	Reline partial upper denture chairside	\$99.00	
05741	Reline partial lower denture chairside	\$99.00	
05750	Reline complete upper denture lab	\$164.00	
05751	Reline complete lower denture lab	\$164.00	

LIST OF MAXIMUM PAYMENTS

Procedure Code	Description	Maximum Payment Effective July 2007	* 6 month waiting period applies
05760	Reline partial upper denture lab	\$159.00	
05761	Reline partial lower denture lab	\$159.00	
05820	Interim partial upper denture	\$149.00	*
05821	Interim partial lower denture	\$149.00	*
05850	Tissue Conditioning upper denture	\$51.00	*
05851	Tissue Conditioning lower denture	\$51.00	*
05860	Overdenture - complete, by report	\$400.00	*
05861	Overdenture - partial, by report	\$340.00	*
06053	Implant/Abutment supported removable denture for completely edentulous arch	\$492.00	*
06054	Implant/Abutment supported removable denture for partially edentulous arch	\$418.00	*
06092	Recement Crown	\$37.00	*
06093	Recement Fixed Denture	\$46.00	*
06205	Pontic - indirect resin based composite	\$210.00	*
06210	Pontic - Cast High Noble Metal	\$373.00	*
06211	Pontic - Cast Predominantly Base Metal	\$322.00	*
06212	Pontic - Cast Noble Metal	\$345.00	*
06214	Pontic - Titanium	\$373.00	*
06240	Pontic - Porcelain Fused to High Noble Metal	\$367.00	*
06241	Pontic - Porcelain Fused to Predominantly Base Metal	\$322.00	*
06242	Pontic - Porcelain Fused to Noble Metal	\$345.00	*
06245	Pontic - porcelain/ceramic	\$345.00	*
06250	Pontic - Resin with High Noble Metal	\$322.00	*
06251	Pontic - Resin with Predominantly Base Metal	\$272.00	*
06252	Pontic - Resin with Noble Metal	\$294.00	*
06545	Retainer - Cast Metal for Resin Bonded Fixed Prosthesis	\$128.00	*
06548	Retainer - Porcelain/Ceramic for resin bonded fixed prosthesis	\$180.00	*
06600	Inlay, porcelain/ceramic, two surfaces	\$450.00	*
06601	Inlay, porcelain/ceramic, three or more surfaces	\$450.00	*
06602	Inlay, cast high noble metal, two surfaces	\$65.00	*
06603	Inlay, cast high noble metal, three or more surfaces	\$81.00	*
06604	Inlay - Cast predominantly base metal, two surfaces	\$130.00	*
06605	Inlay - Cast predominantly base metal, three or more surfaces	\$170.00	*
06606	Inlay - cast noble metal, two surfaces	\$250.00	*
06607	Inlay - cast noble metal, three or more surfaces	\$250.00	*
06608	Onlay, porcelain/ceramic, two surfaces	\$320.00	*
06609	Onlay, porcelain/ceramic, three or more surfaces	\$375.00	*
06610	Onlay - cast noble metal, two surfaces	\$250.00	*
06611	Onlay, cast high noble metal, three or more surfaces	\$339.00	*
06612	Onlay - Cast predominantly base metal, two surfaces	\$130.00	*

LIST OF MAXIMUM PAYMENTS

Procedure Code	Description	Maximum Payment Effective July 2007	* 6 month waiting period applies
06613	Onlay - Cast predominantly base metal, three or more surfaces	\$170.00	*
06614	Onlay - cast noble metal, two surfaces	\$125.00	*
06615	Onlay - cast noble metal, three or more surfaces	\$250.00	*
06624	Inlay -Titanium	\$240.00	*
06634	Onlay - Titanium	\$339.00	*
06710	Crown - Indirect resin based composite	\$160.00	*
06720	Crown - Resin with High Noble Metal	\$326.00	*
06721	Crown - Resin with Predominantly Base Metal	\$275.00	*
06722	Crown - Resin with Noble Metal	\$298.00	*
06740	Crown - (porcelain/ceramic)	\$326.00	*
06750	Crown - Porcelain Fused to High Noble Metal	\$385.00	*
06751	Crown - Porcelain Fused to Predominantly Base Metal	\$337.00	*
06752	Crown - Porcelain Fused to Noble Metal	\$356.00	*
06780	Crown - 3/4 Cast High Noble Metal	\$326.00	*
06781	Crown - 3/4 Cast Predominantly Base Metal	\$275.00	*
06782	Crown - 3/4 Cast Noble Metal	\$298.00	*
06783	Crown - 3/4 Porcelain/Ceramic	\$245.00	*
06790	Crown - Full Cast High Noble Metal	\$385.00	*
06791	Crown - Full Cast Predominantly Base Metal	\$333.00	*
06792	Crown - Full Cast Noble Metal	\$356.00	*
06794	Crown - Titanium	\$385.00	*
06920	Connector Bar	\$120.00	*
06930	Recement Fixed Partial Denture	\$46.00	
06970	Cast Post and Core in Addition to Fixed Partial Denture Retainer	\$116.00	*
06971	Cast Post as part of Fixed Partial Denture Retainer	\$91.00	*
06972	Prefabricated Post and Core in Addition to Fixed Partial Denture Retainer	\$91.00	*
06973	Core Buildup for Retainer, Including any Pins	\$59.00	*
06976	Cast Post - Each additional indirectly fabricated post - same tooth	\$35.00	*
06977	Steel Post - Each additional prefabricated post - same tooth	\$35.00	*
06980	Fixed Partial Denture Repair, by Report	\$86.00	*
07111	Extraction, Coronal Remnants - deciduous tooth	\$36.00	*
07140	Extraction, Erupted Tooth or Exposed Root	\$36.00	*
07210	Surgical removal of erupted tooth requiring elevation of Mucoperiosteal flap and removal of bone and/or section of tooth	\$59.00	*
07220	Removal of Impacted Tooth - Soft Tissue	\$89.00	*
07230	Removal of Impacted Tooth - Partially Bony	\$116.00	*
07240	Removal of Impacted Tooth - Completely Bony	\$143.00	*
07241	Removal of Impacted Tooth - Completely Bony, with Unusual Surgical Complications	\$154.00	*
07250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	\$79.00	*

LIST OF MAXIMUM PAYMENTS

Procedure Code	Description	Maximum Payment Effective July 2007	* 6 month waiting period applies
07260	Fistula/Root Surgery	\$175.00	*
07261	Primary Closure of a Sinus Perforation	\$240.00	*
07270	Tooth replantation	\$100.00	*
07272	Tooth transplantation	\$80.00	*
07280	Surgical access of an unerupted tooth	\$120.00	*
07282	Mobilization of erupted or malpositioned tooth to aid eruption	\$110.00	*
07287	Cytology Sample	\$25.00	*
07288	Brush Biopsy	\$25.00	*
07290	Surgical repositioning of teeth	\$130.00	*
07310	Alveoloplasty, in Conjunction with Extractions - per quadrant	\$59.00	*
07311	Alveoloplasty in Conjunction with Extractions, one to three teeth or tooth spaces, per quadrant	\$35.00	*
07320	Alveoloplasty Not in Conjunction with Extractions - per quadrant	\$86.00	*
07321	Alveoloplasty Not in Conjunction with Extractions - one to three teeth or tooth spaces, per quadrant	\$52.00	*
07340	Vestibuloplasty - ridge extension (secondary epithelialization)	\$300.00	*
07350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$490.00	*
07450	Remove Oodontogenic CYST/Tumor - diameter up to 1.25 cm	\$150.00	*
07451	Remove Oodontogenic CYST/Tumor - diameter greater than 1.25 cm	\$300.00	*
07471	Removal of lateral exostosis	\$150.00	*
07472	Removal of Torus Palatinus	\$200.00	*
07473	Removal of Torus Mandibularis	\$175.00	*
07485	Surgical reduction of osseous tuberosity	\$130.00	*
07510	Incision and drainage of abscess - intraoral soft tissue	\$60.00	*
07511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$75.00	*
07520	Incision and drainage of abscess - extraoral soft tissue	\$95.00	*
07521	Incision and drainage of abscess - extraoral soft tissue (complicated)	\$100.00	*
07960	Frenulectomy - separate	\$90.00	*
07963	Frenuloplasty	\$120.00	*
07970	Excision of Hyperplastic tissue	\$90.00	*
07971	Excision of Pericoronal gingiva	\$45.00	*
07972	Surgical reduction of fibrous tuberosity	\$135.00	*
09110	Palliative (Emergency) Treatment of Dental Pain, Minor Procedure	\$37.00	*
09220	Deep Sedation/General Anesthesia - first 30 minutes	\$81.00	*
09221	Deep Sedation/General Anesthesia - each additional 15 minutes	\$22.00	*
09241	Intravenous Conscious Sedation/Analgesia - first 30 minutes	\$76.00	*
09242	Intravenous Conscious Sedation/Analgesia - each additional 15 minutes	\$19.00	*
09310	Consultation	\$50.00	

LIST OF MAXIMUM PAYMENTS

Procedure Code	Description	Maximum Payment Effective July 2007	* 6 month waiting period applies
09610	Therapeutic Parenteral Drug - single administration	\$18.00	*
09612	Therapeutic Parenteral Drug - two or more administrations, different medication	\$18.00	*
09910	Application of desensitizing medicine	\$12.00	*
09911	Application of desensitizing resin	\$15.00	*
09951	Occlusal Adjustment - limited	\$25.00	*
09952	Occlusal Adjustment - complete	\$100.00	*

EXAMPLES OF POTENTIAL SAVINGS WHEN YOU USE A PARTICIPATING PDP DENTIST

	OUT-OF-NETWORK			IN-NETWORK		
PROCEDURE	Dentist's Usual Charge	Plan Payment	Your Cost	PDP Fee	Plan Payment	Your Cost
#1110 - Cleaning	\$95.00	\$75.00	\$20.00	\$75.00	\$75.00	\$0
#2160 - Filling	\$170.00	\$78.00	\$92.00	\$114.00	\$78.00	\$36.00
TOTAL for the Visit	\$265.00	\$153.00	\$112.00	\$189.00	\$153.00	\$36.00

If you had used a PDP dentist, you would have saved \$76.00

Let's assume you need a crown but you have already received \$850 in plan benefits for the year:

	OUT-OF-NETWORK			IN-NETWORK		
PROCEDURE	Dentist's Usual Charge	Plan Payment	Your Cost	PDP Fee	Plan Payment	Your Cost
#2750 - Crown	\$1,720.00	\$0*	\$1,720.00	\$775.00	\$0*	\$775.00

** annual maximum has been exceeded*

If you had used a PDP dentist, you would have saved \$945.00. You continue to benefit from the PDP Discounts, even when you have exceeded the plan's annual maximum of \$850.00



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